

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

Page 4

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MEDICAL CERTIFICATION

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY				b. STATE			
FREDERICK				MARYLAND			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN 1b			
Frederick				4 hrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
FREDERICK MEMORIAL				870 - 38th Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH			
BABY BOY ALLISON				SEPT 23 1960			
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	
M		W				23 SEPT 60	
9. AGE (In years lost birthday) yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Infant - none		none		Maryland		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
JAMES ALLISON				DORETTA RUGGLES			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
no				none			
17. INFORMANT				Address			
				Frederick Mem Hospital Frederick Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE							
771.5 DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CNS DAMAGE - HEMORRHAGE?							
DUE TO (c) PREMATURITY							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
19						20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 23 SEPT 1960 to 23 SEPT 1960 that (I) saw the deceased alive on 23 SEPT 1960 and that death occurred at 9 P. M. from the causes and on the date stated above.							
22a. SIGNATURE				22b. DATE SIGNED			
FRED J. HELDRICH M.D.				9/23/60			
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
FRED J. HELDRICH M.D.				Frederick, Md			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
Burial		9-26-60		Mt Olivet		Frederick Md.	
24. FUNERAL DIRECTOR'S SIGNATURE				25a. REC'D BY REGISTRAR			
DAILEY'S FUNERAL HOME				25b. REGISTRAR'S SIGNATURE			
FREDERICK, MD.				Charles E. Harris			
10-X 211XV2							

10259

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

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CERTIFICATE OF DEATH

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MARYLAND STATE BOARD OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10240

10260

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. LENGTH OF STAY IN 1b 12 Yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
d. NAME OF HOSPITAL (If not in hospital, give street address) Frederick Memorial Hospital				d. STREET ADDRESS 358 East Third Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARY Middle ANN Last ANDREWS				4. DATE OF DEATH Month September Day 1 Year 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 25 March 1918	
9. AGE (In years last birthday) 42 yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>		IF UNDER 24 HRS. Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work				10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Cologne, Germany	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Elisa Lay			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] No				16. SOCIAL SECURITY NO. 217-30-5647		17. INFORMANT Joseph C. Andrews (Same as item #2)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary of the heart, haemas DUE TO (b) 2 years Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) 2 years DUE TO (b) 2 years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 2 years							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 5-22 19 58 to 9-1 19 60 that (I) (we) last saw the deceased alive on 9-1 19 60 , and that death occurred 8:45 AM , from the causes and on the date stated above.							
22a. SIGNATURE Thomas E. Stone				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 2 Sept 1960	
22c. PHYSICIAN'S NAME (Type) Thomas E. Stone, M. D.				22d. ADDRESS 4 W. 3rd St., Frederick, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 5, 1960		23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		23d. LOCATION (City, town, or county) (State) Frederick, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				25a. REC'D BY REGISTRAR DATE SEP 6 '60		25b. REGISTRAR'S SIGNATURE Arthur L. Thomas	

CERTIFICATE OF DEATH

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 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH

10241

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick-Rural- R.F.D.#1				c. LENGTH OF STAY IN 1b Years			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick -Rural-R.F.D.#1				d. STREET ADDRESS Mt. Pleasant			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Pleasant				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First HARRY Middle THOMAS Last BARNES				4. DATE OF DEATH Month September Day 11 Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 27, 1870		9. AGE (In years last birthday) 90 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm Owner		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel F. Barnes				14. MOTHER'S MAIDEN NAME Ella Kelly			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Miss Edith M. Barnes-Same as Item #1			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute cardiac failure 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cardiovascular disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 2 hrs 5 yrs +						PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 1930 to Sept. 11, 1960 that (I) (we) last saw the deceased alive on Sept. 11, 1960 and that death occurred at 8:30P from the causes and on the date stated above.							
22a. SIGNATURE B. O. Thomas				22b. DATE SIGNED 9/12/1960		22c. PHYSICIAN'S NAME (Type) B. O. Thomas, M.D.	
22d. ADDRESS Professional Building, Frederick, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 14, 1960		23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		23d. LOCATION (City, town, or county) (State) Frederick, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE MurR. Etchison & Son, Frederick, Maryland				25a. REC'D BY REGISTRAR DATE SEP 13 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

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may be returned by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10261

10242

1. PLACE OF DEATH a. COUNTY FREDERICK MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY FRED			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick, Md.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 11 FREDerick, Maryland			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION F. M. H.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JAMES Middle BARNES Last BARNES				4. DATE OF DEATH Month SEPT Day 2 Year 19 60			
5. SEX M		6. COLOR OR RACE C		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 23 JULY 60	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Frederick Mem. Hospital		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME James H. Thompson				14. MOTHER'S MAIDEN NAME Judith BARNES			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address Mrs. Mary Barnes 120 Carver Apts. Fred., Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure 754.4 DUE TO Fibroelastosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1 SEPT 1960 to 2 SEPT 1960 that (I) (we) last saw the deceased alive on 1 SEPT 1960 and that death occurred at 12 PM , from the causes and on the date stated above.							
22a. SIGNATURE F. J. HELDRICH				22b. ADDRESS FRED, MD.		22c. PHYSICIAN'S NAME (Type) F. J. HELDRICH	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-3-1960		23c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery		23d. LOCATION (City, town, or county) (State) FREDERICK, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Charles E. Hicks				25a. REC'D BY REGISTRAR DATE SEP 9 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Hines	

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CERTIFICATE OF DEATH

Reg. Dist. No.

10299

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick rural				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick RD 3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Own Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) W. A. R. Bell			4. DATE OF DEATH Month Sept. Day 22 Year 1960				
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 31, 1883	9. AGE (In years last birthday) 77 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Optometrist		10b. KIND OF BUSINESS OR INDUSTRY Own Business		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Albert Bell				14. MOTHER'S MAIDEN NAME Elizabeth Cashman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 218-34-3956		INFORMANT Mrs. Myrtle Bell		Address Frederick RD 3	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive CVD - chronic left ventricular failure DUE TO (c) Diabetes mellitus, mild						INTERVAL BETWEEN ONSET AND DEATH 24 hours 4 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August , 19 50 , to 9/21 , 19 60 , that I last saw the deceased alive on 9/22 , 19 60 , and that death occurred at 11:55 P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) WALKERSVILLE MD DATE SIGNED 9/23/60							
ACTUAL SIGNATURE James E. Stoner Jr. M.D.							
PHYSICIAN'S NAME (Type) JAMES E. STONER JR.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-25-60		22c. NAME OF CEMETERY OR CREMATORY Utica Cemetery		22d. LOCATION (City, town, or county) (State) Lewisburg Fred. Co. Md	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond B. Beagan				ADDRESS Thurmont, Md.		24c. REC'D BY REGISTRAR DATE SEP 27 1960	
				24b. REGISTRAR'S SIGNATURE Charles S. Kneass			

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

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Blank form with faint lines for text entry.

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS 115 (4)
ISM 9/58

10300 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

10244

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>FREDERICK</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>FREDERICK</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WOODSBORO RURAL</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WOODSBORO RURAL</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last <u>OLIVE ESTELLA BOLINGER</u>		4. DATE OF DEATH Month Day Year <u>SEPT 26 1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 15 - 1886</u>
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>PERRY ORNDORFF</u>		14. MOTHER'S MAIDEN NAME <u>CATHERINE RACEY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
INFORMANT Address <u>WM A BOLINGER WOODSBORO MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive Heart Failure</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Arteriosclerotic Heart Disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>no</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June</u> , 19 <u>58</u> , to <u>Sept 26</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Sept. 26</u> , 19 <u>60</u> , and that death occurred at <u>3:45</u> AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James T. Gray</u>		ADDRESS (Street, city or town, state) <u>Thurmont Md.</u> DATE SIGNED <u>Sept 26 1960</u>	
PHYSICIAN'S NAME (Type) <u>James K. Gray</u>		<u>Thurmont, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>9/29/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>SUGAR HILL</u>	22d. LOCATION (City, town, or county) (State) <u>ZEPR VA</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Dr. Hartzler & Sons</u> ADDRESS <u>New Windsor</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 30 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

CERTIFICATE OF DEATH

100000

1. Name of deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of birth: [illegible]
5. Date of death: [illegible]
6. Place of death: [illegible]
7. Cause of death: [illegible]
8. Signature of physician: [illegible]
9. Signature of registrar: [illegible]
10. Date of registration: [illegible]

TO HOSPITAL by the attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

10262

CERTIFICATE OF DEATH

10245

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Washington D.C. b. COUNTY Washington D.C.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b Months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Monocacy Hall Nursing Home		d. STREET ADDRESS 47X-3	
3. NAME OF DECEASED (Type or print) First Maude Middle Falkenstein Last Chapman		4. DATE OF DEATH Month September Day 20 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 20, 1884
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (State or foreign country) Luray, Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. 1	
17. INFORMANT Mr. F. Wilker Chapman		Address Frederick, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malnutrition - Multiple deep pressure ulcers DUE TO 450.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Advanced arteriosclerosis - Psychosis DUE TO 240.0 (c) Cephalic - Reticular Vaginal prolapse DUE TO 670.0		INTERVAL BETWEEN ONSET AND DEATH 6 mo	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 1960 to 9/70 that (I) (we) last saw the deceased alive on 9/10 19 60 and that death occurred at M , from the causes and on the date stated above.			
22a. SIGNATURE Dr. A. Talbott Brice		22b. DATE SIGNED SEP 26 '60	
22c. PHYSICIAN'S NAME (Type) Dr. A. Talbott Brice		22d. ADDRESS M.D. Jefferson, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-22-1960	
23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION (City, town, or county) (State) Frederick, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Robert E. Gilbey		25a. REC'D BY REGISTRAR Frederick, Maryland	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus		25c. DATE SEP 26 '60	

10039

CENTRAL OF DEATH

10063



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Washington D.C. Washington D.C.

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CERTIFICATE OF DEATH

Reg. Dist. No.

10301

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY —	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Knoxville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION —		d. STREET ADDRESS 1318 James Street	
3. NAME OF DECEASED (Type or print) First Mary Middle Albright Last Chow		4. DATE OF DEATH 9 Month 11 Day 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-8-1885
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Nevert Holmes (Holmes)		14. MOTHER'S MAIDEN NAME Jane Harrison	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. —	
17. INFORMANT Mrs. Daisy Nicklas, Baltimore, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c) Bronchial Asthma		INTERVAL BETWEEN ONSET AND DEATH 6 hrs. 10 yrs. 10 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 12 , 19 59 to Sept 11 , 19 60 that I last saw the deceased alive on Sept. 11 , 19 60 and that death occurred at 5:05 A.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 15 S. Maryland Ave. DATE SIGNED 9-13-60	
ACTUAL SIGNATURE C. T. Byron Kao		PHYSICIAN'S NAME (Type) C. T. Byron Kao, M.D. Brunswick, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-14-1960	22c. NAME OF CEMETERY OR CREMATORY Reformed	22d. LOCATION (City, town, or county) (State) Knoxville, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE B. H. Felt Brunswick, Maryland		24a. REC'D BY REGISTRAR DATE SEP 16 '60	
24b. REGISTRAR'S SIGNATURE Arthur L. Finner			

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1911

[Signature]
Registrar

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TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND										
10263										
CERTIFICATE OF DEATH										
10247										
1. PLACE OF DEATH a. COUNTY Frederick MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick					c. LENGTH OF STAY IN 1b Since-1926					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 240 Dill Avenue					d. STREET ADDRESS 240 Dill Avenue					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
3. NAME OF DECEASED (Type or print) First MARIA Middle CELESTE Last DARKIS					4. DATE OF DEATH Month September Day 4 Year 19 60					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 17 Oct 1875		9. AGE (In years lost birthday) 84 yrs.		
IF UNDER 1 YEAR Months Days Hours Min.										
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work					10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Gideon R. Wachter					14. MOTHER'S MAIDEN NAME Alice Keyser					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)					16. SOCIAL SECURITY NO. None		17. INFORMANT 3010 Surrey Road, Frederick R. Darkis Durham, N. C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO Essential hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Essential hypertension DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1955 to 9/4 19 60 that (I) (we) last saw the deceased alive on 9/3 19 60 and that death occurred at 3A M, from the causes and on the date stated above.										
22a. SIGNATURE James B. Thomas					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 6 Sept 1960			
22c. PHYSICIAN'S NAME (Type) James B. Thomas, M. D.					22d. ADDRESS 228 N. Market St., Frederick, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-6-60		23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery			23d. LOCATION (City, town, or county) (State) Frederick, Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland					ADDRESS		25a. REC'D BY REGISTRAR DATE SEP 9 '60		25b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

CERTIFICATE OF DEATH

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10264

CERTIFICATE OF DEATH

Reg. Dist. No.

10248

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 30 Min.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LULA Middle MAY Last DAVIS		4. DATE OF DEATH Month September Day 19 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 19, 1881
9. AGE (In years lost birthday) yrs. 79		10. IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Kentucky		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Rev. James H. Balter		14. MOTHER'S MAIDEN NAME Caroline Wiggington	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. E. Carl Davis- Same as Item #3		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 19, 1960 , to Sept 19, 1960 , that I last saw the deceased alive on Sept 19, 1960 , and that death occurred at 2:10 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE A.A. Pearre		DATE SIGNED 9/20/60	
PHYSICIAN'S NAME (Type) A.A. Pearre M.D.		ADDRESS (Street, city or town, state) East Church Street Frederick, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Sept. 22, 1960	22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery	22d. LOCATION (City, town, or county) (State) Frederick, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR DATE SEP 22 '60	
24b. REGISTRAR'S SIGNATURE Arthur L. Hines			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

10564

1958

NAME OF DECEASED JAMES H. HARRIS		DATE OF DEATH 10-15-58	
PLACE OF DEATH Home		AGE 65	
SEX Male		RACE White	
MARRIAGE Married		EDUCATION High School	
OCCUPATION Retired		RELIGION Methodist	
CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural	
IMMEDIATE CAUSE Myocardial Infarction		INTERMEDIATE CAUSE Coronary Artery Disease	
FUNDING AGENCY Social Security		BURIAL PLACE Greenwood Cemetery	
SIGNATURE OF PHYSICIAN J. H. Harris		SIGNATURE OF REGISTRAR J. H. Harris	
DATE OF SIGNATURE 10-15-58		DATE OF SIGNATURE 10-15-58	

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

VS. A1SME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10265

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10249

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN lb 2 Hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ijamsville - Rural			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital				d. STREET ADDRESS Pleasant Grove		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MAUDE Middle ETHEL Last DAVIS				4. DATE OF DEATH Month September Day 8 Year 19 60			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 5, 1887		9. AGE (In years last birthday) 72 yrs.	IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Noah Watkins				14. MOTHER'S MAIDEN NAME Julia Linthicum			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-34-2369		17. INFORMANT Address Mr. Edgar W. Davis -Same as Item #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fractured Skull-Sub Dural Hemmorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fractured Pelvis and Ribs on Both Sides DUE TO (c) Fractured Right Leg						INTERVAL BETWEEN ONSET AND DEATH 2 Hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Automobile Accident with auto					
20c. TIME OF INJURY Month, Day, Year 9/8/60		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway		20f. (City or town) (County) (State) Frederick Frederick Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined monner <input type="checkbox"/>							
ACTUAL SIGNATURE B O Thomas				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 9/12/1960	
EXAMINER'S NAME (Type) B. O. Thomas, M. D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 12, 1960		22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				ADDRESS Frederick, Maryland		24a. REC'D BY REGISTRAR DATE SEP 13 '60	
				24b. REGISTRAR'S SIGNATURE Charles S. Hearn			

MEDICAL CERTIFICATION

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MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Death	
John - work		Male		31		1913	
Place of Birth		Race		Color		Religion	
Maryland		White		White		Roman Catholic	
Usual Residence		Occupation		Cause of Death		Manner of Death	
Baltimore, Md.		Laborer		Heart Disease		Natural	
Medical History		Previous Illnesses		Treatment		Post-mortem Examination	
None		None		None		None	
Signature of Examiner		Signature of Coroner		Signature of Physician		Signature of Witness	
J. H. Jones		J. H. Jones		J. H. Jones		J. H. Jones	

10302

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH

10250

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY City ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cullen				c. LENGTH OF STAY IN 1b 455 days			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore				3501-4			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Victor Cullen State Hospital				d. STREET ADDRESS 3420 E. Lombard St			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Stephen First Dockins Middle Last				4. DATE OF DEATH Month 9 Day 27 Year 1960			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-2-1897		9. AGE (In years last birthday) 63 yrs.	IF UNDER 1 YEAR: Months 63 Days 27 Hours 19 Min. 60
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Casimir Dockins				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 220-18-5079		17. INFORMANT Address Record of Victor Cullen Hospital			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Tuberculosis - 002 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 002X DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic heart disease - 420						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (This hospital) attended the deceased from 6/29 1959 to 9/27 1960 that (I) (we) last saw the deceased alive on 9/27 1960 , and that death occurred at 6 PM , from the causes and on the date stated above.							
22a. SIGNATURE Michael G. Zavis M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE 9/27/60	
22c. PHYSICIAN'S NAME (Type) Michael G. Zavis M.D.				22d. ADDRESS Cullen, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10/1/60		23c. NAME OF CEMETERY OR CREMATORY HOLY ROSARY		23d. LOCATION (City, town, or county) (State) BALTIMORE MD	
24. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Grogan				25a. REC'D BY REGISTRAR Thurmont		25b. REGISTRAR'S SIGNATURE Arthur S. Knease	
ADDRESS				DATE OCT 3 '60			

CERTIFICATE OF DEATH

10367

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

10266

CERTIFICATE OF DEATH

10251

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. LENGTH OF STAY IN 1b Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital				d. STREET ADDRESS Tower Apt., East Church Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First MINA Middle AGUSTUS Last EWING				4. DATE OF DEATH Month September Day 27 Year 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 17, 1882	
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work				10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Maryland Conn.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Peter Boyson				14. MOTHER'S MAIDEN NAME Isadora Morgan			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None		17. INFORMANT 1190 North Market Street, Mrs. Helen E. Hursey, Frederick, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Breast DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 170X DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 18 months							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from 6-16 19 59 to 9-27 19 60 that (I) (we) last saw the deceased alive on 9-27 19 60 , and that death occurred 10:35A from the causes and on the date stated above.							
22a. SIGNATURE Thomas E. Stone				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE 9/27/60 SIGNED	
22c. PHYSICIAN'S NAME (Type) Thomas E. Stone, M. D.				22d. ADDRESS West Third Street, Frederick, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 29, 1960		23c. NAME OF CEMETERY OR CREMATORY Frederick Memorial Park		23d. LOCATION (City, town, or county) (State) Frederick, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				ADDRESS		25a. REC'D BY REGISTRAR DATE SEP 28 '60	
				25b. REGISTRAR'S SIGNATURE Arthur L. Evans			

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 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH

10252

10267

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) 238 West Patrick Street				d. STREET ADDRESS 238 West Patrick Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Charles Middle A Last Faust				4. DATE OF DEATH Month September Day 2 Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 31, 1906	9. AGE (In years lost birthday) yrs. 54	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Motel Owner			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Peter C. Faust				14. MOTHER'S MAIDEN NAME Unk.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 520-25-9120		17. INFORMANT Address Mrs. Emma E. Faust 238 W. Patrick St. Fred. Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease with coronary artery disease DUE TO (b) Peptic ulcer Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)							INTERVAL BETWEEN ONSET AND DEATH 5-10 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from Nov 1958 to 9-2-1960 that (I) (we) last saw the deceased alive on 9-2-1960 and that death occurred at 4:45 M, from the causes and on the date stated above.							
22a. SIGNATURE Dr. Rex Martin				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Dr. Rex Martin				22d. ADDRESS 220 North Market Street Frederick, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9-5-60	23c. NAME OF CEMETERY OR CREMATORY Mt. Vernon		23d. LOCATION (City, town, or county) (State) MoKeysport, Pa.			
24. FUNERAL DIRECTOR'S SIGNATURE Robert E. Dailey				ADDRESS Frederick, Maryland		25a. REC'D BY REGISTRAR DATE SEP 6 '60	
				25b. REGISTRAR'S SIGNATURE Arthur S. Kline			

page 33 of 33

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10253

10268

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 200 East Seventh Street		e. STREET ADDRESS 200 East Seventh Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First GRACE Middle MAY Last FOGLE		4. DATE OF DEATH Month September Day 29 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 31, 1878
9. AGE (In years lost birthday) yrs. 82		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Aquilla Wolfe		14. MOTHER'S MAIDEN NAME Aireanna Cutsail	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. Roy F. Fogle—Same as Item #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO Cerebral vascular accident		INTERVAL BETWEEN ONSET AND DEATH 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2-1-1959 to 9-29-1960 , that (I) (we) last saw the deceased alive on 9-14-1960 , and that death occurred 10:30A from the causes and on the date stated above.			
22a. SIGNATURE Rex R. Martin		22b. DATE 10/3/60	
22c. PHYSICIAN'S NAME (Type) Rex R. Martin, M.D.		22d. ADDRESS North Market Street, Frederick, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 3, 1960	
23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		23d. LOCATION (City, town, or county) (State) Frederick, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		25a. REC'D BY REGISTRAR OCT 4 '60	
ADDRESS		25b. REGISTRAR'S SIGNATURE Arthur S. Howard	

10253

CERTIFICATE OF DEATH

10253

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DECEASED
NAME
AGE
SEX
DATE OF BIRTH
PLACE OF BIRTH
DATE OF DEATH
PLACE OF DEATH
CAUSE OF DEATH
SIGNATURE OF REGISTRAR
SIGNATURE OF WITNESSES
DATE OF REGISTRATION

Handwritten signature

2-1-2 27 2-2-1-2

4-14-60

Handwritten signature

Box 1, Station, N.Y.
Box 1, Station, N.Y.
Box 1, Station, N.Y.
Box 1, Station, N.Y.
Box 1, Station, N.Y.

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10254

10269

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. LENGTH OF STAY IN 1b Days				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital				d. STREET ADDRESS 132 West Second Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First LIZZIE Middle EDITH Last FOX				4. DATE OF DEATH Month September Day 25 Year 1960							
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 16, 1876		9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work				10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Francis T. Hopwood						14. MOTHER'S MAIDEN NAME Catherine Rensberg					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Address Miss Elizabeth C. Martin-Same as Item #2					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 600.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Pyelonephritis DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH 1 year 15 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Sept 15, 1960 to Sept 25, 1960 , that (I) (we) last saw the deceased alive on Sept 25, 1960 and that death occurred 10:50P , from the causes and on the date stated above.											
22a. SIGNATURE L. R. Schoolman M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 9/27/60			
22c. PHYSICIAN'S NAME (Type) L. R. Schoolman, M. D.						22d. ADDRESS 810 Toll House Ave., Frederick, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 28, 1960		23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery				23d. LOCATION (City, town, or county) (State) Frederick, Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland						25a. REC'D BY REGISTRAR DATE SEP 30 '60		25b. REGISTRAR'S SIGNATURE Arthur L. Kraw			

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CERTIFICATE OF DEATH

STATE OF CALIFORNIA, COUNTY OF LOS ANGELES

BEFORE ME, the undersigned authority, on this day personally appeared

and acknowledged to me that he was the person whose name is subscribed to the foregoing instrument.

Given under my hand and seal of office this day of

19

at the County of Los Angeles, State of California.

Notary Public for the State of California

My commission expires this day of

19

My office is located at

Los Angeles, California

Witness my hand and seal of office this day of

19

at the County of Los Angeles, State of California.

Notary Public for the State of California

My commission expires this day of

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10255

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. LENGTH OF STAY IN 1b 30 Years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5 North Bentz Street				d. STREET ADDRESS 5 North Bentz Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First ROY Middle CHESTER Last GAVER				4. DATE OF DEATH Month September Day 5 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 13 May 1896	
9. AGE (In years lost birthday) 64 yrs.		IF UNDER 1 YEAR Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman & Machine Operator-Road Construction				10b. KIND OF BUSINESS OR INDUSTRY Myersville, Md.			
11. BIRTHPLACE (State or foreign country) USA				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Charles Gaver				14. MOTHER'S MAIDEN NAME Lulu Leatherman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-10-5325		17. INFORMANT Mrs. Rosie A. Gaver (Same as item #1)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Left Lung 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO				INTERVAL BETWEEN ONSET AND DEATH 16 months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from April 1957 to Sept 5 1960 , that (I) (we) last saw the deceased alive on Sept 4 1960 , and that death occurred at 10:15P M, from the causes and on the date stated above.							
22a. SIGNATURE U. G. Bourne, Jr.				22b. DATE 7 Sept 1960			
22c. PHYSICIAN'S NAME (Type) U. G. Bourne, Jr., M. D.				22d. ADDRESS 24 W. All Saints St., Frederick, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-8-60		23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		23d. LOCATION (City, town, or county) (State) Frederick, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				25a. REC'D BY REGISTRAR DATE SEP 9 '60		25b. REGISTRAR'S SIGNATURE William S. F...	

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TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4
may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND									
10271									
10256									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Frederick MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Loudoun				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lovettsville-Rural-R.F.D.#1				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital					d. STREET ADDRESS 83X3			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last LILLIAN CATHERINE GRAHAM					4. DATE OF DEATH Month Day Year September 2, 1960				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 30, 1905		9. AGE (In years last birthday) 54 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-wife		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Virginia			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Homer Fawley					14. MOTHER'S MAIDEN NAME Bertha Woodward				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)					16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mr. Edgar Graham-Same as Item #2		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 416X Infarction of the brain DUE TO (b) Cerebral embolus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) Rheumatic Heart Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 WKS 2 WKS 15 yrs +									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from Aug 24, 1960 to Sep 2, 1960 , that (I) (we) lost the deceased alive on Sep 2, 1960 , and that death occurred at 5:25AM from the causes and on the date stated above.									
22a. SIGNATURE Henry V. Chase M.D.					22b. DATE SIGNED 9/2/60				
22c. PHYSICIAN'S NAME (Type) Henry V. Chase M.D.					22d. ADDRESS 4 East Church St., Frederick, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 4, 1960		23c. NAME OF CEMETERY OR CREMATORY Union Cemetery			23d. LOCATION (City, town, or county) (State) Lovettsville, Virginia		
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS M.R. Etchison & Son ; Frederick, Maryland					25a. REC'D BY REGISTRAR DATE SEP 6 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Evans		

(M)

(I)

CERTIFICATE OF DEATH

1957

1. Name of deceased

2. Sex

3. Date of birth

4. Place of birth

5. Date of death

6. Cause of death

7. Signature of doctor

8. Signature of registrar

9. Date

10. Signature of informant

11. Date

12. Signature of informant

13. Signature of registrar

14. Signature of informant

15. Signature of registrar

16. Signature of registrar

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10303

CERTIFICATE OF DEATH

Reg. Dist. No.

10257

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Sabillasville		c. LENGTH OF STAY IN 1b Baltimore - 24	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 422 N. East Ave. 24	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) John George Greb		4. DATE OF DEATH Month Sept. Day 4. Year 1960	
5. SEX M	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb 19 1876
9. AGE (In years last birthday) 84 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician U.S. Coast Guard		10b. KIND OF BUSINESS OR INDUSTRY Baltimore Md.	
11. BIRTHPLACE (State or foreign country) Baltimore Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Greb		14. MOTHER'S MAIDEN NAME Annie Catherine ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 219-07-9977	
17. INFORMANT Amelia H. Greb (wife)		Address 422 N. East Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 422-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardiovascular Disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 12 Hrs. 8 Yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9-3 , 1960 , to 9-4 , 1960 , that I last saw the deceased alive on 9-3 , 1960 , and that death occurred at 5:00AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Charles E. Hess 9-4-60 M.D. ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) Charles E. Hess M.D. Smithsburg, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 7. 1960	
22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE HENRY SANDER & SONS, INC.		24a. REC'D BY REGISTRAR DATE SEP 7 '60	
ADDRESS Baltimore Md.		24b. REGISTRAR'S SIGNATURE Arthur L. Hess	

STATE OF MARYLAND DEPARTMENT OF HEALTH - BALTIMORE 18		11.10.13	
CERTIFICATE OF DEATH		11.10.13	
NAME OF DECEASED JAMES H. HARRIS		SEX Male	
AGE 40		DATE OF BIRTH 11.10.13	
PLACE OF BIRTH BALTIMORE, MARYLAND		OCCUPATION LABORER	
MARITAL STATUS Single		CAUSE OF DEATH 1. Myocardial Infarction 2. Atherosclerosis of the coronary arteries	
DATE OF DEATH 11.10.13		TIME OF DEATH 10:15 AM	
PLACE OF DEATH 1010 N. E. ST. BALTIMORE, MD.		SIGNATURE OF PHYSICIAN J. H. HARRIS	
SIGNATURE OF REGISTRAR J. H. HARRIS		SIGNATURE OF WITNESSES J. H. HARRIS	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10804

CERTIFICATE OF DEATH

Reg. Dist. No.

10258

1. PLACE OF DEATH o. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Braddock Heights, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) // Frederick	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Vindobona, Inc.		d. STREET ADDRESS 214 S. Market St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Isabell S. Griffin		4. DATE OF DEATH Month Day Year September 20 19 60	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 30, 1890
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At home	
11. BIRTHPLACE (State or foreign country) Frederick, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Williams B. Storm		14. MOTHER'S MAIDEN NAME Fannie E. Bartgis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT W. Bartgis Storm		Address 214 S. Market St. Frederick, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Pneumomathesis (c) Cerebral Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 9 21 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Explanation		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 3, 19 58, to Sept. 20, 19 60, that I last saw the deceased alive on Sept 19, 19 60, and that death occurred at 3:30 P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Dr. H. L. Fahrney M.D.		ADDRESS (Street, city or town, state) DATE SIGNED 9-21-60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/23/60	
22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, 106 East Church, Fred. Md.		24a. REC'D BY REGISTRAR DATE SEP 23 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Krause			

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
JAMES H. SMITH		Male		45		1880		BALTIMORE		MARYLAND		UNITED STATES		AMERICA	
RACE		COLOR		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		SPECIAL OCCUPATION		MILITARY SERVICE	
White		White		Roman Catholic		Married		High School		Teacher		None		None	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		MEDICAL ATTENDANCE	
1924		BALTIMORE		MARYLAND		UNITED STATES		AMERICA		Heart Disease		Natural		Physician	
DATE OF REPORT		PLACE OF REPORT		CITY OF REPORT		STATE OF REPORT		COUNTRY OF REPORT		REPORTER		TITLE		ADDRESS	
1924		BALTIMORE		MARYLAND		UNITED STATES		AMERICA		J. H. SMITH		Physician		123 Main St.	
SIGNATURE OF REPORTER		TITLE		ADDRESS		CITY		STATE		COUNTRY		DATE		TIME	
J. H. SMITH		Physician		123 Main St.		BALTIMORE		MARYLAND		UNITED STATES		1924		10:00 AM	

FOR STATE
HEALTH DEPT.

10272

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First DAISY Middle ESPHERA Last GROVE		4. DATE OF DEATH Month September Day 29 , Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 27, 1877
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George A. Babel		14. MOTHER'S MAIDEN NAME Marselena M. Kolb	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. George E. B. Grove—Same as Item #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE 9040 DUE TO Fractured right hip Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 12 hrs DUE TO (c) 12 hrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fractured Hip—Due to Fall			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell	
20c. TIME OF INJURY Month, Day, Year 9/28/1960 Hour 4:20 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) At Home	20f. (City or town) (County) (State) Frederick Frederick Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE B. O. Thomas		DATE SIGNED 9/30/60	
EXAMINER'S NAME (Type) B. O. Thomas, M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Oct. 1, 1960	22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery	22d. LOCATION (City, town, or county) (State) Frederick, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR DATE OCT 3 '60	
		24b. REGISTRAR'S SIGNATURE Arthur S. Evans	

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race		Date of Death		Time of Death		Place of Death		Cause of Death		Manner of Death	
George A. Handel		35		Male		White		1940		10:30 P.M.		Home		Heart Disease		Natural	
Residence		Occupation		Education		Marital Status		Previous Illnesses		Alcohol Consumption		Tobacco Use		Drugs		Other	
1234 Main St., Baltimore, Md.		Teacher		High School		Married		None		Occasional		Occasional		None		None	
Signature of Physician		Signature of Medical Examiner		Signature of Coroner		Signature of Registrar		Signature of Burial Officer		Signature of Undertaker		Signature of Funeral Home		Signature of Cemetery		Signature of Other	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

RECEIVED
BALTIMORE, MARYLAND
JAN 10 1940

18192

CERTIFICATE OF DRAIN

WATERLANDS OF THE DISTRICT OF COLUMBIA
OFFICE OF THE DISTRICT ENGINEER
WASHINGTON, D.C.

18192

1

MADE IN
UNITED STATES
OF AMERICA
© 1915 J. W. M. CO.

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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M
069

10273

10261

10273

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>FREDERICK</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>FREDERICK</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FREDERICK</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X ROUTE 3 Frederick</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>FREDERICK MEMORIAL HOSPITAL</u>				d. STREET ADDRESS <u>Route 3</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>Robert</u> Last <u>GUE</u>				4. DATE OF DEATH Month <u>SEPTEMBER</u> Day <u>27</u> Year <u>1960</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>FEB. 17, 1870</u>	
9. AGE (In years last birthday) <u>90</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <u>Lewisdale, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Stone Mason</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Mason</u>			
13. FATHER'S NAME <u>LORENZA</u>				14. MOTHER'S MAIDEN NAME <u>CARRIE BURDETTE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Mrs Robert Weddle, R.#3, Frederick, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>GENERALIZED ARTERIOSCLEROSIS</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>? ABDOMINAL NEOPLASM - ORIGIN UNDETERMINED</u> 6 MONTHS DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>YEARS</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>AUGUST 13</u> 19 <u>60</u> , to <u>SEPT. 27</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>SEPT. 27</u> 19 <u>60</u> , and that death occurred at <u>11 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Richard C. Reynolds</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>9/28/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>Richard C. Reynolds</u>				22d. ADDRESS <u>Frederick, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/30/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Marvin Chapel</u>		23d. LOCATION (City, town, or county) (State) <u>Plane #4, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Chas. L. Wolsworth</u>				ADDRESS <u>Damascus, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 30 1960</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles L. Wolsworth</u>			

1001



CERTIFICATE OF DEATH

1911

(M)

Blank form with horizontal lines for text entry.

(1)

1030 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 22d Film G271 9-29-60 et

Reg. Dist. No.

FOR STATE
HEALTH DEPT

M

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Sabillasville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Sabillasville	
c. LENGTH OF STAY IN lb Lifetime		d. STREET ADDRESS Own Home	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Henson Middle William Last Harbaugh		4. DATE OF DEATH Month Sept. Day 24. Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 6. 1909
9. AGE (In years last birthday) 50 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer.	
11. BIRTHPLACE (State or foreign country) Frederick Co. Md		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Martin L. Harbaugh		14. MOTHER'S MAIDEN NAME Mary B. Harbaugh.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 216-I4-5447	
17. INFORMANT Mary C. Harbaugh		Address Sabillasville Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Self Inflicted Gun Shot Wound Head and neck DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 3000 seconds
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Self-inflicted wound	
20c. TIME OF INJURY Month, Day, Year 9/24 1960 Hour o. m. 2 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home, farm in Sabillasville Frederick, Md		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE B.O. Thomas		DATE SIGNED Sept. 24. 1960	
EXAMINER'S NAME (Type) B.O. Thomas Frederick Md		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REINTERMENT Burial		22b. DATE THEREOF Sept. 27. 1960	
22c. NAME OF CEMETERY OR CREMATORY St Jacobs Cem.		22d. LOCATION (City, Adams Co. Pa (State) Nr. Sabillasville Fredk. Co Md	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Creager		ADDRESS Thurmont. MD	
24a. REC'D BY REGISTRAR SEP 27 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH OFFICE

(14)

(1)

WESTLAND STATE DEPARTMENT OF HEALTH - SALMON 10

10-10-10 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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10307

CERTIFICATE OF DEATH

Reg. Dist. No.

10263

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Myersville				c. LENGTH OF STAY IN 1b 46 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Route # 2				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last CARRIE SUSAN HARNE				4. DATE OF DEATH Month Day Year September 14 1960			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 14, 1886	
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Frederick Co. Md.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME John E. Kuhn				14. MOTHER'S MAIDEN NAME Martha Swope			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		INFORMANT Address Milton W. Harne, Myersville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO 287X Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Hypertensive Cardiovascular Disease DUE TO Obesity (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
INTERVAL BETWEEN ONSET AND DEATH 1 Hr. 5 Yrs. 10 Yrs.							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 7-4 , 1960 , to 9-14 , 1960 , that I last saw the deceased alive on 9-7 , 1960 , and that death occurred at 11:00 A. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Smithsburg, Md. DATE SIGNED 9-15-60							
ACTUAL SIGNATURE Charles F. Hess M.D.							
PHYSICIAN'S NAME (Type) Charles F. Hess							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		Sept. 17, 1960		United Brethern		Garfield, Fred. Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Paul F. Bittle ADDRESS Myersville, Md.				24a. REC'D BY REGISTRAR DATE SEP 19 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Hous	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1967

CERTIFICATE OF DEATH

14

1. Name of deceased: [illegible]
2. Date of death: [illegible]
3. Place of death: [illegible]

4. Cause of death: [illegible]
5. Manner of death: [illegible]

6. Signature of medical officer: [illegible]
7. Signature of registrar: [illegible]

8. Date of registration: [illegible]
9. Place of registration: [illegible]

10. Signature of informant: [illegible]
11. Date of completion: [illegible]

12. Signature of registrar: [illegible]
13. Date of completion: [illegible]

14. Signature of registrar: [illegible]
15. Date of completion: [illegible]

16. Signature of registrar: [illegible]
17. Date of completion: [illegible]

18. Signature of registrar: [illegible]
19. Date of completion: [illegible]

20. Signature of registrar: [illegible]
21. Date of completion: [illegible]

10293

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick 35	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 203 West "B"		d. STREET ADDRESS 203 West "B" 1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Elizabeth Nixon H overmale		4. DATE OF DEATH Month Day Year 9 27 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-6-1892
9. AGE (In years last birthday) yrs. 68		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John A. Nixon		14. MOTHER'S MAIDEN NAME Mary A. Pearry	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. INFORMANT Charles W. Hovermale, Brunswick, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of Stomach DUE TO (c) Carcinomatosis of Peritoneum		INTERVAL BETWEEN ONSET AND DEATH 3 days 6 mon. 2 mon.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 19, 1958 to Sept. 27, 1960 that I last saw the deceased alive on Sept. 27, 1960 and that death occurred at 3:55 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 15 S. Maryland Ave. Brunswick, Md. DATE SIGNED 9-28-60			
ACTUAL SIGNATURE C.T. Byron Kao, M.D.		PHYSICIAN'S NAME (Type) C.T. Byron Kao, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-29-1960	
22c. NAME OF CEMETERY OR CREMATORY St. Marks		22d. LOCATION (City, town, or county) (State) Petersville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE B. H. Feels		24a. REC'D BY REGISTRAR DATE OCT 3 '60	
ADDRESS Brunswick, Maryland		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be released by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF BIRTH

10233

DATE OF BIRTH

1907

PLACE OF BIRTH

1907

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TO HOSPITAL—ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10274

CERTIFICATE OF DEATH

Reg. Dist. No. 10265

1. PLACE OF DEATH o. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 10 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Myersville	
		d. STREET ADDRESS 1 route # 1	
		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JAMES Middle EDGAR Last HUBBLE		4. DATE OF DEATH Month September Day 21 Year 19 60	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 16, 1875
9. AGE (In years lost birthday) 84 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Farmer		10b. KIND OF BUSINESS OR INDUSTRY own Gen. Farm	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Andy Hubble		14. MOTHER'S MAIDEN NAME Amanda Harmon	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Henry Hubble, Myersville, Md. Rt. # 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August , 19 60 , to 9/21 , 19 60 , that I last saw the deceased alive on 9/20 , 19 60 , and that death occurred at 1:30 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE James B. Thomas		M.D.	
PHYSICIAN'S NAME (Type) James B. Thomas		Frederick, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 24, 1960	
22c. NAME OF CEMETERY OR CREMATORY Zion		22d. LOCATION (City, town, or county) (State) Zion, Smythe Co. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Paul F. Bittle		ADDRESS Myersville, Md.	
24a. REC'D BY REGISTRAR SEP 26 '60		24b. REGISTRAR'S SIGNATURE Anthony S. Hume	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
10275
CERTIFICATE OF DEATH

10266

1. PLACE OF DEATH a. COUNTY Frederick Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Frederick		c. LENGTH OF STAY IN 1b 30 Days.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Middletown		d. STREET ADDRESS 1 Rural	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First George C. Middle Huffer Last 		4. DATE OF DEATH Month Sept. Day 19 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 12, 1882
9. AGE (In years lost birthday) 78 yrs.	IF UNDER 1 YEAR Months 6 Days 7	IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Day Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm Work	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Huffer		14. MOTHER'S MAIDEN NAME Anna Shafer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Floyd Huffer		Address Jefferson, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH 9 c days unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized Jaundice cause undetermined		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9/15 19 60 to 9/19 19 60 that (I) (we) last saw the deceased alive on 9/16 19 60 and that death occurred at 2:40 from the causes and on the date stated above.			
22a. SIGNATURE Kenneth C. Henson		22b. DATE SIGNED 9/20/60	
22c. PHYSICIAN'S NAME (Type) Kenneth C. Henson		22d. ADDRESS Middletown Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 28, 60	
23c. NAME OF CEMETERY OR CREMATORY Reformed Cemetery		23d. LOCATION (City, town, or county) (State) Middletown Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Gladhill Company		24a. REC'D BY REGISTRAR SEP 22 '60	
ADDRESS Middletown, Md.		25b. REGISTRAR'S SIGNATURE William S. Henson	

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UNITED STATES OF AMERICA

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UNITED STATES OF AMERICA
DEPARTMENT OF THE INTERIOR
BUREAU OF LAND MANAGEMENT
WASHINGTON, D. C. 20250

TO: [illegible]
FROM: [illegible]
SUBJECT: [illegible]

[illegible text follows]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

10276

10267

1. PLACE OF DEATH a. COUNTY Frederick County b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fred. c. LENGTH OF STAY IN 1b Lifetime		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Fred. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick City, Maryland	
3. NAME OF DECEASED (Type or print) First Grafton Middle E Last JACKSON		4. DATE OF DEATH Month 9 Day 11 Year 1960	
5. SEX M	6. COLOR OR RACE C	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 24, 1902
9. AGE (In years 57 birthday) 37 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during preceding life, even if retired) None		11. BIRTHPLACE (State or foreign country) mt. Pleasant, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Robert Agustus Jackson	
14. MOTHER'S MAIDEN NAME Mary Elizabeth Costley		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. 220-05-6295		17. INFORMANT Charles E. Jackson Address 166 W. All Saints Street	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of head of pancreas (Laparotomy) Feb. 1960 DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	
20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____		21. I certify that I attended the deceased from Feb. 12 , 1960, to Sept. 11 , 1960, that I last saw the deceased alive on Sept. 11 , 1960, and that death occurred at 6 P. M, from the causes and on the date stated above.	
ACTUAL SIGNATURE Ralph L. Michels, M.D. M.D. Shopping Center		ADDRESS (Street, city or town, state) Frederick, Maryland	
PHYSICIAN'S NAME (Type) Ralph L. MICHELS		DATE SIGNED _____	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-14-1960	
22c. NAME OF CEMETERY OR CREMATORY Wayman A. M. E.		22d. LOCATION (City, town, or county) Mt. Pleasant, Maryland (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Hicken ADDRESS 111 24 W. All Saints Street		24a. REC'D BY REGISTRAR SEP 16 '60	
24b. REGISTRAR'S SIGNATURE Charles E. Hicken			

CERTIFICATE OF DEATH

10336

1. PLACE OF DEATH Home		2. SEX Male	
3. AGE 65		4. RACE White	
5. DATE OF DEATH Jan 15, 1924		6. TIME OF DEATH 10:30 AM	
7. CAUSE OF DEATH Heart Disease		8. DISEASE OR INJURY Coronary Artery Sclerosis	
9. PLACE OF BIRTH Maryland		10. DATE OF BIRTH Jan 1, 1859	
11. NAME OF DECEASED John Doe		12. NAME OF FATHER John Doe	
13. NAME OF MOTHER Jane Doe		14. NAME OF SPOUSE Mary Doe	
15. NAME OF CHILDREN None		16. NAME OF SIBLINGS None	
17. NAME OF NEAREST RELATIVE John Doe		18. NAME OF PHYSICIAN Dr. John Doe	
19. NAME OF BURIAL PLACE None		20. NAME OF FUNERAL HOME None	
21. NAME OF MINISTER None		22. NAME OF CHURCH None	
23. NAME OF CEMETERY None		24. NAME OF GRAVE None	
25. NAME OF INTERVIEWER None		26. NAME OF WITNESS None	
27. NAME OF REGISTRAR None		28. NAME OF CLERK None	
29. NAME OF ASSISTANT None		30. NAME OF OFFICE None	

13-14
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10277

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10268

Item 2, Film G271 9-16-60 et

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b Month	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lorenzo Middle Jefferies Last Jefferies		4. DATE OF DEATH Month September Day 5 Year 19 60	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 17, 1922
9. AGE (in years last birthday) 38 yrs.		IF UNDER 1 YEAR Months 38 Days 38 Hours 38 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Greensboro, N.C.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Bert Jefferies		14. MOTHER'S MAIDEN NAME Cindy Dickie	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hemorrhage, Punctured left lung, 822X DUE TO Ruptured Spleen, Lacerated left Kidney Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Fractured ribs on left side 5TH to 12th (c) Fractured ribs on left side 5TH to 12th			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Interval between onset and death 1 1/2 hours			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Riding on top of truck of corn, turned over and thrown	
20c. TIME OF INJURY Month. Day. Year II-30 9/5/60 19		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route 67		20f. (City or town) (County) (State) Nr. Weaverton Frederick Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE B.O. Thomas		DATE SIGNED September 6, 1960	
EXAMINER'S NAME (Type) B.O. Thomas, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-9-60	22c. NAME OF CEMETERY OR CREMATORY Fairview Cem.	22d. LOCATION (City, town, or county) (State) Frederick, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Morton & Syttner Dir. Belts, Md.		24a. REC'D BY REGISTRAR DATE SEP 13 '60	
		24b. REGISTRAR'S SIGNATURE William S. Harris	

STATE OF
HEALTH

NEW YORK

NOTICE TO THE PUBLIC
The following is a list of the names of the persons who have died in this State during the month of January, 1900.

1900

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NEW YORK STATE DEPARTMENT OF HEALTH

1900

Name of Deceased		Sex		Age		Date of Death		Place of Death	
John Doe		Male		35		Jan 15, 1900		New York City	
Cause of Death		Disease		Symptoms		Time of Death		Signature of Medical Examiner	
Heart Disease		Myocarditis		Chest pain, shortness of breath		10:30 AM		[Signature]	
Occupation		Residence		Marital Status		Religion		Burial Place	
Teacher		123 Main St		Married		Catholic		St. Mary's Church	
Signature of Medical Examiner		Signature of Coroner		Signature of Registrar		Signature of Minister		Signature of Undertaker	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

10278

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10269

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b Years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 104 East Fifth Street		d. STREET ADDRESS 104 East Fifth Street	
3. NAME OF DECEASED (Type or print) First LILLY Middle MAE Last KEFAUVER		4. DATE OF DEATH Month September Day 16 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH September 27, 1885
9. AGE (In years and birthday) 74 yrs.		IF UNDER 1 YEAR Months 7 Days 19 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jahn Thomas Crouse		14. MOTHER'S MAIDEN NAME Beanie Mehrling	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Address Mrs. Ruth N. Brightwell- Same as Item #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma stomach 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 year			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept 15, 1960 to Sept 16, 1960 , that (I) (we) last saw the deceased alive on Sept 15, 1960 and that death occurred at 3:30 PM , from the causes and on the date stated above.			
22a. SIGNATURE B. O. Thomas		22b. DATE SIGNED 9/17/60	
22c. PHYSICIAN'S NAME (Type) B. O. Thomas, M. D.		22d. ADDRESS Professional Building, Frederick, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 19, 1960	
23c. NAME OF CEMETERY OR CREMATORY Reformed Cemetery		23d. LOCATION (City, town, or county) (State) Middletown, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison		25a. REC'D BY REGISTRAR DATE SEP 20 '60	
ADDRESS Frederick, Maryland		25b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

1
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 10296
 CERTIFICATE OF DEATH

10270

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Airy		c. LENGTH OF STAY IN 1b 10 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Daisy Catherine Lawson		4. DATE OF DEATH Month Sept. Day 18 Year 1960	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 27, 1915
9. AGE (In years last birthday) 45 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Arvlee Bridges		14. MOTHER'S MAIDEN NAME Goldie Chipley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 217-10-9146	
17. INFORMANT Mr. George C. Lawson, Mt. Airy, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Status Asthmaticus 241X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Bronchial Asthma DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 4 days 1 1/2 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb 19 59 to Sept 19 60 , that (I) (we) lost the deceased on Sept. 18 19 60 , and that death occurred on 9/18/60 M, from the causes and on the date stated above.			
22a. SIGNATURE W.B. Culwell		22b. DATE SIGNED 9/18/60	
22c. PHYSICIAN'S NAME (Type) W.B. Culwell		22d. ADDRESS Mt. Airy, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9-21-60	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet	23d. LOCATION (City, town, or county) (State) Frederick, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE Francis W. Bonber		25a. REC'D BY REGISTRAR SEP 22 '60	
ADDRESS Laytonsville, Md.		25b. REGISTRAR'S SIGNATURE Arthur L. Kline	

1970

CERTIFICATE OF TRAINING

10235

Station: _____

Mr. _____

Class: _____

Grade: _____

Unit: _____

Subject: _____

Score: _____

Remarks: _____

Signature: _____

Station: _____

Signature: _____

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

(M)

094

(I)

MEDICAL CERTIFICATION

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10271

10279

1. PLACE OF DEATH o. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montevue				d. STREET ADDRESS 267 West Fifth Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First MARGARET Middle ELLEN Last LEASE				4. DATE OF DEATH Month September Day 19 Year 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 23, 1872	
9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR Months 5 Days 20 Hours 1 Min.		IF UNDER 24 HRS. Months 5 Days 20 Hours 1 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work				10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Amos Lease				14. MOTHER'S MAIDEN NAME Mary Houck			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 214-10-1788		17. INFORMANT Mr. Russell L. Michael, Frederick, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Aortic Stenosis DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 5 yrs + 5 yrs +							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from Jan. 1940 to Sept 17 1960 , that (I) (we) last saw the deceased alive on Sept 18 1960 , and that death occurred at 3:30A from the causes and on the date stated above.							
22a. SIGNATURE B. O. Thomas				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE 9/20/1960	
22c. PHYSICIAN'S NAME (Type) B. O. Thomas, M. D.				22d. ADDRESS Professional Building, Frederick, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 21, 1960		23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		23d. LOCATION (City, town, or county) (State) Frederick, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				ADDRESS		25a. REC'D BY REGISTRAR DATE SEP 22 '60	
						25b. REGISTRAR'S SIGNATURE Arthur L. Hines	

1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 26

TO HOSPITAL - ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
10280
CERTIFICATE OF DEATH

10272

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick Memorial</u>		d. STREET ADDRESS <u>Locust ST</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>JAMES EDWARD Lee</u>		4. DATE OF DEATH Month Day Year <u>Sept 22 1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>22 Sept 60</u>
9. AGE (In years lost birthday) yrs. <u>10 20</u>		IF UNDER 1 YEAR Months Days Hours Min. <u>10 20</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>md.</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James F. Lee</u>		14. MOTHER'S MAIDEN NAME <u>Helen E. Langwecker</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>James Lee</u>		Address <u>Union Bridge</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Immaturity</u> 761.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Placenta Praevia</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>22 Sept, 1960</u> to <u>22 Sept, 1960</u> that (I) (we) lost saw the deceased alive on <u>22 Sept, 1960</u> and that death occurred at <u>3:45 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>A. M. Powell</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>A. M. POWELL M.D.</u>		22d. ADDRESS <u>FREDERICK MARYLAND</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>9/23/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>ST. PETERS CEM.</u>		23d. LOCATION (City, town, or county) (State) <u>LIBERTY TOWN MD</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>D. D. [Signature]</u>		24b. ADDRESS <u>Union Bridge, MD.</u>	
25a. REC'D BY REGISTRAR DATE <u>SEP 26 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Charles S. Thomas</u>	

2069242XU1

10315

CERTIFICATE OF DEATH

10315

(M)

(C)

(1)

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

10281

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10273

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 7 Months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Three Pines Nursing Home		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Adamstown -Rural-R.F.D.#1	
d. STREET ADDRESS Hope Hill Road		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First IDA Middle MAY Last LENHART		4. DATE OF DEATH Month September Day 28 , Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 26, 1878
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months 82 Days 82 Hours 82 Min. 82	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Benjamin F. Lenhart		14. MOTHER'S MAIDEN NAME Margaret Purdy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. George H. W. Lenhart-Same as Item #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the Breast DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 170X (c) 170X		INTERVAL BETWEEN ONSET AND DEATH 2 years.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4/1/1960 to 4/8/1960 that (I) (we) last saw the deceased alive on 8/30/1960 and that death occurred at 4:00P M, from the causes and on the date stated above.			
22a. SIGNATURE Richard C. Reynolds		22b. DATE 9/30/60	
22c. PHYSICIAN'S NAME (Type) R. C. Reynolds, M. D.		22d. ADDRESS East Church Street, Frederick, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 1, 1960	
23c. NAME OF CEMETERY OR CREMATORY Flint Hill Methodist Cem.		23d. LOCATION (City, town, or county) (State) Frederick County, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		25a. REC'D BY REGISTRAR DATE OCT 3 '60	
25b. REGISTRAR'S SIGNATURE Arthur L. Thomas			

bp

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10274

10282

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b Years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First KATHERINE Middle MACKLEY Last MARMOR		4. DATE OF DEATH Month September Day 23 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 31 Aug 1904
9. AGE (In years last birthday) 56 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John E. Ridenour		14. MOTHER'S MAIDEN NAME Nancy M. Mackley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) UNK	
17. INFORMANT Joseph P. Marmor (Same as item #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive Heart Failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c) Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 1 week	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus Acute Pyelonephritis Obesity		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept 18 19 60 to Sept 23 19 60 that (I) (we) last saw the deceased alive on Sept 23 19 60 , and that death occurred at 8:45 A M, from the causes and on the date stated above.			
22a. SIGNATURE A. A. Pearre		22b. DATE SIGNED 24 Sept 1960	
22c. PHYSICIAN'S NAME (Type) A. A. Pearre, M. D.		22d. ADDRESS 4 E. Church St., Frederick, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-26-60	
23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		23d. LOCATION (City, town, or county) (State) Frederick, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		25a. REC'D BY REGISTRAR DATE SEP 27 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

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CERTIFICATE OF DEATH

10545

A. A. Lewis, M. D.

A. A. Lewis, M. D.

Frederick, Maryland

Mount Olive Cemetery

9-23-10

Final

A. A. Lewis & Son, Frederick, Maryland

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10297

10275

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurmont				c. LENGTH OF STAY IN 1b Lifetime			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Own Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First William Middle Henry Last Martin				4. DATE OF DEATH Month September Day 3 Year 1960			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 5, 1881	9. AGE (In years last birthday) 79 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Timberman		10b. KIND OF BUSINESS OR INDUSTRY Self Emp.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Martin				14. MOTHER'S MAIDEN NAME Ella Sipes			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. No		17. INFORMANT Mrs. Stella Martin		Address Thurmont, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Arteriosclerosis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 10 days 2 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Aug 24 19 60 , to Sept 3 19 60 , that (I) (we) last saw the deceased alive on Sept 2 19 60 and that death occurred at 10:30 M, from the causes and on the date stated above.							
22a. SIGNATURE James T. Gray				22b. DATE SIGNED Sept 3-60			
22c. PHYSICIAN'S NAME (Type) James T. Gray				22d. ADDRESS Thurmont, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-6-60		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State) Thurmont, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Crea				25a. REC'D BY REGISTRAR DATE SEP 6 '60		25b. REGISTRAR'S SIGNATURE Arthur L. Frank	

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10308

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE W. Va. b. COUNTY Berkeley ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Ijamsville				c. LENGTH OF STAY IN 1b 6 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Riggs Hospital				d. STREET ADDRESS 922 Kaufman Ave.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Barbara Ellen McBee				4. DATE OF DEATH Month Day Year Sept 17 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec 13 1892	
9. AGE (In years lost birthday) 67 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Duties				10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) W. Va.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Charles Housholder				14. MOTHER'S MAIDEN NAME Lillian Roach			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. no			
17. INFORMANT Wilbert McBee (Husband)				Address Martinsburg, WV			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cardiovascular Disease Auricular Fibrillation DUE TO (c) Atherosclerosis							
INTERVAL BETWEEN ONSET AND DEATH 1 day 3 years 3 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19							
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Sept 11, 1960 to Sept 17, 1960 , that I last saw the deceased alive on Sept 17, 1960 , and that death occurred at 12, 10M , from the causes and on the date stated above. P ADDRESS (Street, city or town, state) Ijamsville Md. DATE SIGNED							
ACTUAL SIGNATURE Joseph Lerner M.D.							
PHYSICIAN'S NAME (Type) Joseph Lerner M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-20-1960		22c. NAME OF CEMETERY OR CREMATORY Spohrs Cross Roads		22d. LOCATION (City, town, or county) (State) Morgan County, West Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Howard K. Brown				ADDRESS Martinsburg, W. Va.		24a. REC'D BY REGISTRAR SEP 20 '60	
				24b. REGISTRAR'S SIGNATURE Arthur J. Kneiss			

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DECLARATION OF DEATH

1936

No. 1

Deceased

322 Madison Ave.

IA

Deceased

Robert Louis (husband)

Warren County, N.Y.

John Doe, Jr.

1936

Warren County, N.Y.

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10309

10277

1. PLACE OF DEATH, a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CULLEN		c. LENGTH OF STAY IN 1b 340 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase		1527.2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OF INSTITUTION 004 Victor Cullen State Hospital		d. STREET ADDRESS 2804 Blaine Drive	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Charles Middle H. Last McKimmie		4. DATE OF DEATH Month 9 Day - 20 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/23/1913
9. AGE (In years last birthday) 47 yrs.	IF UNDER 1 YEAR Months 1 Days 28	IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY —	11. BIRTHPLACE (State or foreign country) Washington, D.C.
12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Oscar A. McKimmie		14. MOTHER'S MAIDEN NAME Marion Grist	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service) W.W.II		16. SOCIAL SECURITY NO. 224-14-8230	
17. INFORMANT Record of Victor Cullen State Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Tuberculosis - 002 002X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH 11 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10/5/59 to 9/20/60 , that (I) (we) last saw the deceased alive on 9/19/59 , and that death occurred at 1:30 AM from the causes and on the date stated above.			
22a. SIGNATURE Michael G. Zavis		22b. DATE, SIGNATURE 9/20/60	
22c. PHYSICIAN'S NAME (Type) Michael G. ZAVIS, M.D.		22d. ADDRESS Cullen, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF SEPT. 23/60	
23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NAT. CEM.		23d. LOCATION (City, town, or county) (State) ARLINGTON, VA.	
24. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Krueger - Thammert M.		25a. REC'D BY REGISTRAR DATE SEP 21 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Kneass			

Mortimer W. Hyman 60 - Wash. D. C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

10295 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

10278
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Emmitsburg,		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Emmitsburg,	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 816 West Main		d. STREET ADDRESS 816 West Main	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Charles Middle Henry Last Myers		4. DATE OF DEATH Month September Day 14 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 11, 1875
9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Carroll Co. Md.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John H. Myers		14. MOTHER'S MAIDEN NAME Rose Sehman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-26-1359	
17. INFORMANT Mrs. Joseph Kreitz,		Address 816 West Main St. Emmitsburg, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure DUE TO 260X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease (c) Diabetes Mellitus		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 1954 to 14 Sept 1960 , that I last saw the deceased alive on 14 Sept 1960 , and that death occurred at 4 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE George L. Morningstar M.D.			
PHYSICIAN'S NAME (Type) GEORGE L. MORNINGSTAR, Emmitsburg, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 17, 1960	
22c. NAME OF CEMETERY OR CREMATORY New St. Joseph's		22d. LOCATION (City, town, or county) (State) Emmitsburg, Frederick Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE C. E. Wilson ADDRESS Emmitsburg, Md.		24a. REC'D BY REGISTRAR DATE SEP 16 '60	
24b. REGISTRAR'S SIGNATURE C. E. Wilson			

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TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10310

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10279

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Adamstown				c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Adamstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HATTIE Middle FLORENCE Last O'HARA				4. DATE OF DEATH Month September Day 15 Year 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 17, 1870	
9. AGE (In years last birthday) yrs. 90		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work				10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME James B. Scarff				14. MOTHER'S MAIDEN NAME Eliza Douglas			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs. Edith Yingling, Same as Item #1	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Senility DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH 5-10 years							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Frederick		20g. (County) Frederick		20h. (State) Maryland			
21. I certify that (I) (this hospital) attended the deceased from Dec 8-25 19 60 to 9-15 19 60 , that (I) (we) last saw the deceased alive on 8-25 19 60 and that death occurred 11:30P from the causes and on the date stated above.							
22a. SIGNATURE Rex R. Martin				M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 9/16/60	
22c. PHYSICIAN'S NAME (Type) Rex R. Martin, M. D.				22d. ADDRESS 220 North Market St., Frederick, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 19, 1960		23c. NAME OF CEMETERY OR CREMATORY Manor Reformed Cemetery		23d. LOCATION (City, town, or county) (State) Frederick County, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				ADDRESS		25a. REC'D BY REGISTRAR DATE SEP 19 1960	
				25b. REGISTRAR'S SIGNATURE Arthur S. Hines			

CERTIFICATE OF DEATH

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10283

CERTIFICATE OF DEATH

Reg. Dist. No.

10280

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegheny			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. LENGTH OF STAY IN 1b 3 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 907 Shawnee Drive, Frederick, Md				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Albert Middle - Last O'Neal				4. DATE OF DEATH Month Sept Day 18 Year 19 60			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 28, 1869	9. AGE (In years last birthday) 90 yrs.	IF UNDER 1 YEAR Months 11 Days 20	IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer (Retired)				10b. KIND OF BUSINESS OR INDUSTRY Farm Owner		11. BIRTHPLACE (State or foreign country) Chaneysville, Penna...	12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME B. Frederick O'Neal				14. MOTHER'S MAIDEN NAME Harriet Lashley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 220-34-1432		17. INFORMANT Mrs Rosanna M. Stemp-Same as D. above		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarct 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic myocarditis DUE TO (c) Arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH 10 min. 34 m. 2 yr.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Alcohol							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 1959 to Sept 1960 , that I last saw the deceased alive on Dec 19 59 , and that death occurred at 5 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE H. F. Kline		ADDRESS (Street, city or town, state) DATE SIGNED Frederick Md. 777 Market St. Sept 1960					
PHYSICIAN'S NAME (Type) Dr. H. F. Kline		7 North Market St. Frederick, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/21/60		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Md	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR DATE SEP 21 '60	
				24b. REGISTRAR'S SIGNATURE Charles L. Kline			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

10284

CERTIFICATE OF DEATH

Reg. Dist. No.

10281

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. LENGTH OF STAY IN 1b 6 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital				e. STREET ADDRESS Braddock			
3. NAME OF DECEASED (Type or print) First WALTER Middle SHERIDAN Last REEDER				4. DATE OF DEATH Month September Day 29 Year 19 60			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 17 March 1871	9. AGE (In years last birthday) 89 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm Owner		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Josephus Reeder				14. MOTHER'S MAIDEN NAME Mary Ann Baer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Joseph L. Reeder (Same as item #2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Arteriosclerosis 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Fracture Right hip DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH years 1 week
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4/12 , 19 60 , to 9/30 , 19 60 , that I last saw the deceased alive on 9/30 , 19 60 , and that death occurred at 4 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 9 E. Church St., DATE SIGNED 30 Sept 1960							
ACTUAL SIGNATURE Richard C. Reynolds M.D.				PHYSICIAN'S NAME (Type) Richard C. Reynolds, M. D. Frederick, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-2-60		22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				24a. REC'D BY REGISTRAR DATE OCT 3 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10081

CERTIFICATE OF DEATH

10284

1. NAME OF DECEASED J. Edgar Hoover		2. SEX Male	
3. AGE 54 years		4. DATE OF BIRTH May 10, 1895	
5. PLACE OF BIRTH Washington, D.C.		6. OCCUPATION Special Agent in Charge, Federal Bureau of Investigation	
7. MARITAL STATUS Married		8. DATE OF MARRIAGE June 12, 1917	
9. NAME OF SPOUSE Alice C. Hoover		10. DATE OF DEATH February 6, 1955	
11. PLACE OF DEATH Washington, D.C.		12. CAUSE OF DEATH Myocardial infarction	
13. MEDICAL HISTORY Hypertension, Atherosclerosis		14. PRESENT ILLNESS Sudden death	
15. SIGNATURE OF PHYSICIAN J. Edgar Hoover		16. SIGNATURE OF WITNESSES J. Edgar Hoover, Alice C. Hoover	
17. SIGNATURE OF DEATH REGISTRAR J. Edgar Hoover		18. SIGNATURE OF CLERK J. Edgar Hoover	

10081

1. NAME OF DECEASED
J. Edgar Hoover

2. SEX
Male

3. AGE
54 years

4. DATE OF BIRTH
May 10, 1895

5. PLACE OF BIRTH
Washington, D.C.

6. OCCUPATION
Special Agent in Charge, Federal Bureau of Investigation

7. MARITAL STATUS
Married

8. DATE OF MARRIAGE
June 12, 1917

9. NAME OF SPOUSE
Alice C. Hoover

10. DATE OF DEATH
February 6, 1955

11. PLACE OF DEATH
Washington, D.C.

12. CAUSE OF DEATH
Myocardial infarction

13. MEDICAL HISTORY
Hypertension, Atherosclerosis

14. PRESENT ILLNESS
Sudden death

15. SIGNATURE OF PHYSICIAN
J. Edgar Hoover

16. SIGNATURE OF WITNESSES
J. Edgar Hoover, Alice C. Hoover

17. SIGNATURE OF DEATH REGISTRAR
J. Edgar Hoover

18. SIGNATURE OF CLERK
J. Edgar Hoover

10311

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wt Army R O I</u>		c. LENGTH OF STAY IN 1b <u>6 YRS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>near Ridgerville</u> X			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <u>R. D #1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Edgar</u> Middle <u>Arnold</u> Last <u>Rhinecker</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>7</u> Year <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 25, 1900</u>		9. AGE (In years last birthday) <u>60</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General</u>		11. BIRTHPLACE (State or foreign country) <u>Frederick Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Harry Rhinecker</u>				14. MOTHER'S MAIDEN NAME <u>FANNIE R. HOWMAN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>217-09-6333</u>		17. INFORMANT Address <u>Wt Army R O I</u> <u>Robert Buckman</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gun Shot wound of brain</u> 976X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Gun Shot wound of brain Self inflicted</u>					
20c. TIME OF INJURY Month <u>9</u> Day <u>7</u> Year <u>1960</u> Hour <u>2</u> a. m. <input checked="" type="checkbox"/> p. m. <input type="checkbox"/>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Wt Army R O I Frederick Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>B. O. Thomas, md</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>B. O. Thomas, md</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>SEPT-10-1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Locust Grove Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Frederick Co Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. M. Waltz, Winfield, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>SEP 9 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1911

1908

Form with multiple sections for medical examination and death certification, including fields for name, age, sex, cause of death, and signature.

NAME OF DECEASED		AGE		SEX	
DATE OF DEATH		PLACE OF DEATH		CITY	
CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF EXAMINER	
DATE OF EXAMINATION		PLACE OF EXAMINATION		CITY	
FAMILY HISTORY		SOCIAL HISTORY		PHYSICAL EXAMINATION	
LABORATORY EXAMINATIONS		RADIOLOGICAL EXAMINATIONS		PATHOLOGICAL EXAMINATIONS	
TREATMENT		PROGNOSIS		REMARKS	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10285

CERTIFICATE OF DEATH

10283

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>FREDERICK</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>FREDERICK</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FREDERICK CITY</u>		c. LENGTH OF STAY IN 1b <u>49 YEARS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FREDERICK CITY</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>522 TRAIL AVE.</u>				d. STREET ADDRESS <u>522 TRAIL AVE.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>LILLIAN KATHERINE SHOW</u>			4. DATE OF DEATH Month Day Year <u>SEPTEMBER 26 19 60</u>				
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JANUARY-8-1879</u>	9. AGE (In years last birthday) <u>81</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>KEEDYSVILLE WASH. CO. MD. U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>SAMUEL ROHRER</u>			14. MOTHER'S MAIDEN NAME <u>MARY ETTA PARKS</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO.</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>HENRY J. SHOW</u> Address <u>522 TRAIL AVE. FREDERICK MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Cardiovascular disease</u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 hrs +</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan.</u> , 19 <u>34</u> , to <u>Sept. 26</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Sept. 24</u> , 19 <u>60</u> , and that death occurred at <u>9:30</u> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>228 N. Market St. Frederick, Md.</u> DATE SIGNED <u>Sept. 26, 1961</u>							
ACTUAL SIGNATURE <u>B. O. Thomas</u> M.D.							
PHYSICIAN'S NAME (Type) <u>B. O. Thomas M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>SEPT. 29, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>FAIRVIEW CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>KEEDYSVILLE WASH. CO. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Bost</u>				ADDRESS <u>BOONSBORO MD.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	
				24c. REC'D BY REGISTRAR DATE <u>OCT 3 '60</u>			

CERTIFICATE OF DEATH

3024

THE DAY OF

DECEASED: (Name of deceased) (Last, first, middle initial)
 (Date of birth) (Month, day, year)
 (Place of birth) (City, State, Country)

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 10284

10286

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Frederick b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick c. LENGTH OF STAY IN TB 2 Yrs d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) East All Saints Street				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick d. STREET ADDRESS 142 West Patrick Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First HARRY Middle FRANKLIN Last SIER				4. DATE OF DEATH Month September Day 5 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 22 March 1906	
9. AGE (In years last birthday) 54 yrs.		IF UNDER 1 YEAR Months 54 Days 54		IF UNDER 24 HRS. Hours 54 Min. 54			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Veterinary Clinic		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William A. Sier				14. MOTHER'S MAIDEN NAME Lillie May			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 217-10-9351		17. INFORMANT Mr. William A. Sier, 13 W. South St., Frederick, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema 527.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 527.2 DUE TO (c) 527.2 INTERVAL BETWEEN ONSET AND DEATH 10 Minutes							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 527.2							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour 19 a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE B. O. Thomas				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 7 Sept 1960	
EXAMINER'S NAME (Type) B. O. Thomas, M. D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-8-60		22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				ADDRESS Frederick, Maryland		24a. REC'D BY REGISTRAR SEP 9 '60	
				24b. REGISTRAR'S SIGNATURE Arthur L. Huns			

MEDICAL CERTIFICATION

FOR STATE
REAL ESTATE
BOND

10288

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased JAMES H. HARRIS		Sex Male		Age 37	
Date of Death April 15, 1941		Place of Death Home		Cause of Death Heart Disease	
Occupation Salesman		Usual Residence 1234 Main St., Baltimore, Md.		Manner of Death Natural	
Signature of Medical Examiner J. H. Harris		Signature of Coroner J. H. Harris		Signature of Registrar J. H. Harris	
Date of Certificate April 15, 1941		Time of Death 10:00 AM		Place of Burial Catholic Cemetery	
Signature of Registrar J. H. Harris		Signature of Coroner J. H. Harris		Signature of Medical Examiner J. H. Harris	
Date of Certificate April 15, 1941		Time of Death 10:00 AM		Place of Burial Catholic Cemetery	

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

10287

CERTIFICATE OF DEATH

10285

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		d. STREET ADDRESS 446 West South Street	
3. NAME OF DECEASED (Type or print) First NORA Middle FLORENCE Last STAUB		4. DATE OF DEATH Month September Day 16 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 23, 1895
9. AGE (In years last birthday) yrs. 65		IF UNDER 1 YEAR: Months 5 Days 16 Hours 16 Min. 16	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James McCuller		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-26-0336	
17. INFORMANT Mr. Melvin F. Staub-Same as Item #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cornary thrombosis DUE TO 260X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardio-vascular Disease (c) Diabetes mellitus		INTERVAL BETWEEN ONSET AND DEATH 3 hours 54 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 1, 1958 to Sept 16, 1960 that (I) (we) last saw the deceased alive on Sept 15, 1960 and that death occurred at 12:05A from the causes and on the date stated above.			
22a. SIGNATURE James B. Thomas M.D.		22b. DATE SIGNED 9/16/60	
22c. PHYSICIAN'S NAME (Type) James B. Thomas, M. D.		22d. ADDRESS Professional Building, Frederick, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 19, 1960	
23c. NAME OF CEMETERY OR CREMATORY Frederick Memorial Park		23d. LOCATION (City, town, or county) (State) Frederick, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		25a. REC'D BY REGISTRAR SEP 20 '60	
ADDRESS		25b. REGISTRAR'S SIGNATURE Charles L. Thomas	

1083

CERTIFICATE OF DEATH

1083



NAME OF DECEASED
RESIDENCE
DATE OF DEATH
PLACE OF DEATH
CAUSE OF DEATH
SIGNATURE OF REGISTRAR
OFFICE OF THE REGISTRAR

[Faint, illegible handwritten text, possibly a signature or address]

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

10286

10294

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick		c. LENGTH OF STAY IN 1b 18 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) B.&O.Rail Road Yards		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Albert Middle Berkley Last Stokes		4. DATE OF DEATH Month 9 Day 2 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-26-1916
9. AGE (In years last birthday) 44 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brakeman	11. BIRTHPLACE (State or foreign country) West Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Joseph H. Stokes	
14. MOTHER'S MAIDEN NAME Susan Taylor		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No If yes, give war or dates of service	
16. SOCIAL SECURITY NO.		17. INFORMANT Address Bertha Stokes, Brunswick, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 800X DUE TO DECAPITATED Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DECAPITATED DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour 11.03 a. m. 9-2 19 60	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) B. & O. Yards	20f. (City or town) Brunswick (County) Frederick (State) Md
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE B. O. Thomas		DATE SIGNED 9/2/1960	
EXAMINER'S NAME (Type) B. O. Thomas		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Frederick, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-5-1960	22c. NAME OF CEMETERY OR CREMATORY Springs Mills	22d. LOCATION (City, town, or county) (State) Spring Mills, West Virginia
23. FUNERAL DIRECTOR'S SIGNATURE P. R. Feste ADDRESS Brunswick, Maryland		24a. REC'D BY REGISTRAR SEP 6 '60 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

NOTATION

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF EXAMINER	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY	
16. SIGNATURE OF MEDICAL EXAMINER		17. SIGNATURE OF JURY		18. SIGNATURE OF CORONER	
19. SIGNATURE OF WITNESS		20. SIGNATURE OF JURY		21. SIGNATURE OF CORONER	
22. SIGNATURE OF MEDICAL EXAMINER		23. SIGNATURE OF JURY		24. SIGNATURE OF CORONER	
25. SIGNATURE OF WITNESS		26. SIGNATURE OF JURY		27. SIGNATURE OF CORONER	
28. SIGNATURE OF MEDICAL EXAMINER		29. SIGNATURE OF JURY		30. SIGNATURE OF CORONER	
31. SIGNATURE OF WITNESS		32. SIGNATURE OF JURY		33. SIGNATURE OF CORONER	
34. SIGNATURE OF MEDICAL EXAMINER		35. SIGNATURE OF JURY		36. SIGNATURE OF CORONER	
37. SIGNATURE OF WITNESS		38. SIGNATURE OF JURY		39. SIGNATURE OF CORONER	
40. SIGNATURE OF MEDICAL EXAMINER		41. SIGNATURE OF JURY		42. SIGNATURE OF CORONER	
43. SIGNATURE OF WITNESS		44. SIGNATURE OF JURY		45. SIGNATURE OF CORONER	
46. SIGNATURE OF MEDICAL EXAMINER		47. SIGNATURE OF JURY		48. SIGNATURE OF CORONER	
49. SIGNATURE OF WITNESS		50. SIGNATURE OF JURY		51. SIGNATURE OF CORONER	
52. SIGNATURE OF MEDICAL EXAMINER		53. SIGNATURE OF JURY		54. SIGNATURE OF CORONER	
55. SIGNATURE OF WITNESS		56. SIGNATURE OF JURY		57. SIGNATURE OF CORONER	
58. SIGNATURE OF MEDICAL EXAMINER		59. SIGNATURE OF JURY		60. SIGNATURE OF CORONER	
61. SIGNATURE OF WITNESS		62. SIGNATURE OF JURY		63. SIGNATURE OF CORONER	
64. SIGNATURE OF MEDICAL EXAMINER		65. SIGNATURE OF JURY		66. SIGNATURE OF CORONER	
67. SIGNATURE OF WITNESS		68. SIGNATURE OF JURY		69. SIGNATURE OF CORONER	
70. SIGNATURE OF MEDICAL EXAMINER		71. SIGNATURE OF JURY		72. SIGNATURE OF CORONER	
73. SIGNATURE OF WITNESS		74. SIGNATURE OF JURY		75. SIGNATURE OF CORONER	
76. SIGNATURE OF MEDICAL EXAMINER		77. SIGNATURE OF JURY		78. SIGNATURE OF CORONER	
79. SIGNATURE OF WITNESS		80. SIGNATURE OF JURY		81. SIGNATURE OF CORONER	
82. SIGNATURE OF MEDICAL EXAMINER		83. SIGNATURE OF JURY		84. SIGNATURE OF CORONER	
85. SIGNATURE OF WITNESS		86. SIGNATURE OF JURY		87. SIGNATURE OF CORONER	
88. SIGNATURE OF MEDICAL EXAMINER		89. SIGNATURE OF JURY		90. SIGNATURE OF CORONER	
91. SIGNATURE OF WITNESS		92. SIGNATURE OF JURY		93. SIGNATURE OF CORONER	
94. SIGNATURE OF MEDICAL EXAMINER		95. SIGNATURE OF JURY		96. SIGNATURE OF CORONER	
97. SIGNATURE OF WITNESS		98. SIGNATURE OF JURY		99. SIGNATURE OF CORONER	
100. SIGNATURE OF MEDICAL EXAMINER		101. SIGNATURE OF JURY		102. SIGNATURE OF CORONER	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

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1

MARYLAND STATE BOARD OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

10288

CERTIFICATE OF DEATH

10287

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick			c. LENGTH OF STAY IN 1b 45 Years		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First MERTIE Middle BELL Last STORR			4. DATE OF DEATH Month September Day 23 Year 1960		
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 4 July 1872		9. AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME John H. Bostian		14. MOTHER'S MAIDEN NAME Rebecca Metz	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs. Lula I. Martz, Keymar, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.0 IMMEDIATE CAUSE (a) Serum DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Anteroseptic heart disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 year 1 year					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from 9-16-1960 to 9-23-1960 , that (I) (we) last saw the deceased alive on 9-23-1960 , and that death occurred at 9A M, from the causes and on the date stated above.					
22a. SIGNATURE Rex R. Martin M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED 24 Sept 1960					
22c. PHYSICIAN'S NAME (Type) Rex R. Martin, M. D. 22d. ADDRESS 220 N. Market St., Frederick, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-26-60		23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery	
23d. LOCATION (City, town, or county) (State) Frederick, Maryland					
24. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				25a. REC'D BY REGISTRAR DATE SEP 27 '60	
				25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

10588

(M)

(1)

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10288

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

10289

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. LENGTH OF STAY IN TB 30 hrs.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Floyd First Middle Last Floyd Lee Summers				4. DATE OF DEATH Month September Day 9 Year 19 60			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 1 1938		9. AGE (In years last birthday) 22 yrs.	IF UNDER 1 YEAR Months 22 Days 22 Hours 22 Min.	IF UNDER 24 HRS. Hours 22 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm laborer		10b. KIND OF BUSINESS OR INDUSTRY Frederick Co.		11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Floyd V. Summers				14. MOTHER'S MAIDEN NAME Loretta Blickenstaff			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or not known) NO		16. SOCIAL SECURITY NO. 215-34-3487		17. INFORMANT Address Hospital records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fractured Skull DUE TO Cerebral Edema Conditions, if any, which gave rise to immediate cause (b) Congestive Heart Failure (a), stating the underlying cause lost. DUE TO Congestive Heart Failure (c) Congestive Heart Failure							INTERVAL BETWEEN ONSET AND DEATH 30 hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter no. of injury and port of entry) Piece of metal got in ensilage blower and was blown out and struck him in face					
20c. TIME OF INJURY Month, Day, Year 3 p.m. 9/8/60 19		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) On farm		20f. (City or town) (County) (State) Mr. Doubs Frederick Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE B.O. Thomas				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) B.O. Thomas, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-13-60		22c. NAME OF CEMETERY OR CREMATORY Mt. Dale Ch. of Breth.		22d. LOCATION (City, town, or county) (State) Mountaindale Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Creger				ADDRESS Thurmont, Maryland		24a. REC'D BY REGISTRAR DATE SEP 15 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

WYOMING STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Residence	
Sex		Age	
Race		Color	
Date of Death		Place of Death	
Cause of Death		Manner of Death	
Signature of Medical Examiner		Signature of Coroner	
Date of Certificate		Place of Issuance	



WYOMING STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
10312
CERTIFICATE OF DEATH

10289

1. PLACE OF DEATH a. COUNTY <u>FREDERICK</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>FREDERICK</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SMITHSBURG MD. R.I.</u>				d. STREET ADDRESS <u>SMITHSBURG MD. R.I.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARGARET SWEITZER</u>				4. DATE OF DEATH Month Day Year <u>SEPT. 4 - 19 60</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>MARCH 18 1870</u>	
9. AGE (In years lost birthday) <u>90</u> yrs.		IF UNDER 1 YEAR Months <u>5</u> Days <u>16</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE KEEPER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>LITTLE ORLEANS MP. U.S.A.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>JOHN SWEITZER</u>				14. MOTHER'S MAIDEN NAME <u>NO RECORD</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>ROLLIN W. TWIGG SMITHSBURG MD. R.I.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>6 Yrs.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>12-2-57</u> 19 <u>57</u> to <u>9-4-60</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>9-4-60</u> 19 <u>60</u> , and that death occurred at <u>6 P.</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Charles F. Hess</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>9-6-60</u>	
22c. PHYSICIAN'S NAME (Type) <u>Charles F. Hess</u>				22d. ADDRESS <u>Smithsburg, M.D.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>SEPT. 7, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>PINEY PLAINS CEMETERY NR. HANCOCK</u>		23d. LOCATION (City, town, or county) (State) <u>WASH. CO. MD</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John H. East</u>				ADDRESS <u>BOONSBORO MD.</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 8 '60</u>	
						25b. REGISTRAR'S SIGNATURE <u>C. L. S. Kline</u>	

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

10812



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10290 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 10290
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ijamsville R.F.D.I			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital				d. STREET ADDRESS None R. F. D.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Wesley Last Timpson				4. DATE OF DEATH Month August Day Sept. 1 Year 19 60			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Marcy 28, 1901		9. AGE (In years last birthday) 59 yrs.	IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Frederick County		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Timpson				14. MOTHER'S MAIDEN NAME Rachel Price			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-30-9148		17. INFORMANT John Timpson Jr. Ijamsville R.F.D.I			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac Failure DUE TO Cardiovascular heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Hypertension DUE TO (c) Hypertension							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour 19 a. m. 0 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE B.O. Thomas				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) B.O. Thomas, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-4-1960		22c. NAME OF CEMETERY OR CREMATORY St. Paul A. M. E. Church		22d. LOCATION (City, town, or county) (State) Della, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Hicks III, 24 W. All Saints Street				ADDRESS Frederick, Maryland		24a. REC'D BY REGISTRAR SEP 9 '60	
				24b. REGISTRAR'S SIGNATURE Arthur L. Knead			

MEDICAL CERTIFICATION

FOR STATE
HEALTH DEPT.

10230 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		RESIDENCE	
SEX		AGE	
DATE OF DEATH		PLACE OF DEATH	
CAUSE OF DEATH		MANNER OF DEATH	
DISEASE		INJURY	
SYMPTOMS		TREATMENT	
HISTORY		FAMILY HISTORY	
PHYSICAL EXAMINATION		LABORATORY EXAMINATIONS	
POSTMORTEM EXAMINATION		OTHER EXAMINATIONS	
SIGNATURE OF EXAMINER		DATE	
OFFICE		COUNTY	
STATE		FEDERAL BUREAU OF INVESTIGATION	

10313 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 CERTIFICATE OF DEATH

10291

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Emmitsburg,		c. LENGTH OF STAY IN 1b 73 years	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Emmitsburg,		d. STREET ADDRESS R.D.#1	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D.#1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Murray Middle Ellsworth Last Turner		4. DATE OF DEATH Month September Day 7, Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 22, 1886
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months 73 Days 73 Hours 73 Min. 73	IF UNDER 24 HRS. Months 73 Days 73 Hours 73 Min. 73
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Frederick Co. Md.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jacobus Turner		14. MOTHER'S MAIDEN NAME Catherine Shuyler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 195-26-9008	
17. INFORMANT Leonard Turner, Emmitsburg, R.D.#1, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of liver DUE TO (b) with metastases - generalized DUE TO (c) lying cause last.		INTERVAL BETWEEN ONSET AND DEATH 6 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/27 , 19 60 , to 9/7 , 19 60 that I last saw the deceased alive on 9/7 , 19 60 , and that death occurred at 8:20 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE C.W. Lindeman, M.D.		DATE SIGNED 9.7.60	
PHYSICIAN'S NAME (Type) C.W. Lindeman, M.D. 1 W. Main Street, Waynesboro, Franklin,		ADDRESS (Street, city or town, state)	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 10, 1960	
22c. NAME OF CEMETERY OR CREMATORY Friends Creek Cemetery Emmitsburg, R.D.#1, Md.		22d. LOCATION (City, town, or county) Frederick (State) Obenna	
23. FUNERAL DIRECTOR'S SIGNATURE C. E. Wilson		ADDRESS Emmitsburg, Md.	
24a. REC'D BY REGISTRAR SEP 13 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10291

10292

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WALTER Middle JACOB Last VIRTS		4. DATE OF DEATH Month September Day 20 , Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 16, 1890
9. AGE (In years last birthday) yrs. 69		IF UNDER 1 YEAR Months 6 Days 4 Hours 15 Min. 00	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY RailRoad	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Marshall L. Virts		14. MOTHER'S MAIDEN NAME Della Shellman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 705-12-1650	
17. INFORMANT Mrs. N. W. Maney, Same as Item #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9/18, 1960 to 9/20, 1960 that (I) (we) last saw the deceased alive on 9/19, 1960 and that death occurred on 9/20, 1960 from the causes and on the date stated above.			
22a. SIGNATURE A. T. Brice		22b. DATE SIGNED 9/20/60	
22c. PHYSICIAN'S NAME (Type) A. T. Brice, M. D.		22d. ADDRESS Jefferson, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 23, 1960	
23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		23d. LOCATION (City, town, or county) (State) Frederick, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		25a. REC'D BY REGISTRAR DATE SEP 22 '60	
25b. REGISTRAR'S SIGNATURE Arthur L. Hume			

(continued from page 6)

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

10292

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10293

Item 12 Film 272 10-3-60 et

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 1 year	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick		35	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montevue		d. STREET ADDRESS 21 East "C" Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Andrew Young Wilson		4. DATE OF DEATH Month Day Year 9 23 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-25-1868
9. AGE (In years and birth day) 92 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Machinist		10b. KIND OF BUSINESS OR INDUSTRY B.&O.R.R.Co	
11. BIRTHPLACE (State or foreign country) Greenock, Scotland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Wilson		14. MOTHER'S MAIDEN NAME Dont Know	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 	
17. INFORMANT Mrs. Paul V. Smith, Brunswick, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic myocarditis 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Senility DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH 5715	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 1949 to Sept 22, 1960 , that (I) (we) last saw the deceased alive on Sept 11, 1960 , and that death occurred at PM , from the causes and on the date stated above.			
22a. SIGNATURE H.F. Kline		22b. DATE SIGNED Sept 23 60	
22c. PHYSICIAN'S NAME (Type) H.F. KLINE MD		22d. ADDRESS 777 Market St. Frederick Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-25-1960	
23c. NAME OF CEMETERY OR CREMATORY Mt. Zion		23d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE B. L. Felt		25a. REC'D BY REGISTRAR SEP 26 '60	
ADDRESS Brunswick, Maryland		25b. REGISTRAR'S SIGNATURE Arthur L. House	

10202

UNITED STATES OF AMERICA

10202

(M)

Department of the Interior
Bureau of Land Management
Washington, D. C. 20250

TO: Mr. J. Edgar Hoover, Director, Federal Bureau of Investigation
FROM: Mr. W. A. Rorer, Chief of Bureau, Bureau of Land Management
SUBJECT: [Illegible]

RE: [Illegible]

Enclosed for the Bureau are two copies of a letterhead memorandum dated and captioned as above.

Very truly yours,
[Illegible Signature]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

10314

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

M

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) R.F.D. #1, Adamstown				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rural Rt. 1 Adamstown				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Leroy Joseph Middle Wolfe Last Wolfe				4. DATE OF DEATH Month 9 Day 13 Year 1960			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/26/1914		9. AGE (In years last birthday) 46 yrs.	10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer Construction				10b. KIND OF BUSINESS OR INDUSTRY *****		11. BIRTHPLACE (State or foreign country) Frederick County, Md.	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Harry Charles Wolfe			
14. MOTHER'S MAIDEN NAME Caroline Rosaline Wolfe Spencer				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. Unknown				17. INFORMANT Police Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 3rd. degree burns DUE TO 91630 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 91630 DUE TO (c) 91630							INTERVAL BETWEEN ONSET AND DEATH Minutes
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 91630							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Home caught on fire			
20c. TIME OF INJURY Hour 9:30 m. p. Month, Day, Year 9 13 1960		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Adamstown (County) Frederick (State) Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE B. O. Thomas M.D.				DATE SIGNED 9/14/1960			
EXAMINER'S NAME (Type) B. O. Thomas, M. D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 17-60		22c. NAME OF CEMETERY OR CREMATORY St. Pauls A.M.E.		22d. LOCATION (City, town, or county) (State) Della Fred. Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE C.E. Hicks III				ADDRESS Frederick, Maryland			
24a. REC'D BY REGISTRAR DATE SEP 20 '60				24b. REGISTRAR'S SIGNATURE Clinton S. Thomas			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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